820 PRIOR AUTHORIZATION REQUIREMENTS

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I. PURPOSE

This Policy applies to Fee-For-Service (FFS) Programs and populations as delineated within this Policy including: Tribal ALTCS, TRBHAs, the American Indian Health Program (AIHP); and all FFS populations, excluding Federal Emergency Services (FES). (For FES, see AMPM Chapter 1100). This Policy establishes FFS Prior Authorization requirements for covered services.

II. DEFINITIONS

PRIOR AUTHORIZATION (PA)	For purposes of this policy, A process by which the AHCCCS Division of Fee-For-Service (FFS) Management (DFSM) determined in advance whether a service that requires prior approval will be covered, based on the initial information received. PA may be granted provisionally (as a temporary authorization) pending receipt of required documentation to substantiate compliance with AHCCCS criteria. PA is not a guarantee of payment.
PRIOR AUTHORIZATION REQUEST SUBMISSION PROCESS	The process by which authorization requests are submitted with clinical documentation supporting the medical necessity for the services requested.

III. POLICY

PA is not required for FFS members receiving services from Indian Health Services (IHS)/638 providers and facilities, or for emergency services. A non-IHS/638 provider or facility rendering AHCCCS covered services shall obtain PA from the AHCCCS Administration/Division of Fee-For-Service Management (DFSM) /Prior Authorization area, hereafter referred to as DFSM for services requiring authorization as specified in this Policy. PA requests shall be submitted prior to providing services.

The DFSM procedural requirements for submitting PA requests via the AHCCCS online web portal (preferred), fax, telephone, or mail, as delineated in AMPM Policy 810, apply to all services identified in this Policy, unless specified otherwise. For purposes of this Policy, all PA requests are submitted to the DFSM for approval or denial, unless specified otherwise. In

the case of a service denial, termination, suspension, or reduction, notice will be provided in accordance with 9 A.A.C. 34.

A. PRIOR AUTHORIZATION REQUEST SUBMISSION PROCESS

For additional information related to FFS authorization submission requirements and procedures, visit the Prior Authorization page under the Fee-For-Service section of the AHCCCS website.

Refer to the AHCCCS Fee-for-Service Provider Manual for information regarding submission of claims and billing procedures. This manual is available online at the AHCCCS website.

B. BEHAVIORAL HEALTH

AHCCCS covers behavioral health services and/or substance use disorder services within limitations depending upon the member's age and eligibility.

Outpatient behavioral health services for Tribal ALTCS members are coordinated through the Tribal ALTCS case manager. Outpatient behavioral health services for FFS members assigned to a RBHA for behavioral health services are authorized by the assigned RBHA. For TRBHA assigned members, FFS providers coordinate behavioral health services with the assigned TRBHA. American Indian members may also receive behavioral health services at an Indian Health Service or tribally owned or operated 638 facilities.

Refer to AMPM Policy 310 and the AHCCCS Covered Behavioral Health Services Guide for further information regarding AHCCCS covered behavioral health services and settings.

C. BREAST RECONSTRUCTION AFTER MASTECTOMY

AHCCCS covers breast reconstruction for eligible FFS members following a medically necessary mastectomy. Refer to AMPM Policy 310-C.

PA is required for breast reconstruction surgery provided to FFS members.

Refer to the sections of this Policy addressing Hospital Inpatient Stays and Physician Services for authorization documentation requirements.

D. COCHLEAR IMPLANT

AHCCCS covers medically necessary services for cochlear implantation for FFS Early and Periodic Screening, Diagnosis and Treatment (EPSDT) members at an AHCCCS registered implantation center. PA is required for all cochlear implants and related services for FFS members. Requests for PA shall include documentation of the appropriate assessments and evaluations for determining suitability for a cochlear implant.

Refer to AMPM Policy 430 for complete information regarding covered cochlear implant services.

1. The following documentation shall accompany the authorization request:
   a. The member's current history and physical examination, including information regarding previous therapy for the hearing impairment,
   b. Records documenting the member's diagnosis, current medical status and plan of treatment leading to the recommendation of cochlear implant, and
   c. Current psychosocial evaluation and assessment for determining the member's suitability for cochlear implant.

E. DENTAL SERVICES

AHCCCS provides dental services for members who are under the age of 21 in both the AHCCCS (EPSDT Program) and KidsCare Programs. Refer to AMPM Policy 430, for complete information regarding covered dental services for these members.

AHCCCS provides coverage of dental services for members 21 years of age and older within the limitations as outlined in AMPM Policy 310-D1 and AMPM Policy 310-D2 Dental services for Tribal ALTCS members 21 years of age and older are coordinated by the member's Tribal Case Manager.

1. Preventive and therapeutic dental services for members who are under the age of 21 in both the AHCCCS (EPSDT Program) and KidsCare Programs do not require PA. However, the following services for these members do require PA:
   a. Removable dental prosthetics, including complete dentures and removable partial dentures,
   b. Cast crowns,
   c. Orthodontia services, and
   d. Pre-transplant dental services (these services require PA by the AHCCCS DHCM MM transplant coordinator and review by the AHCCCS Dental Director or Designee)

2. Dental PA requests shall be accompanied by:
   a. Dentist substantiation of medical necessity of services through description of medical condition,
   b. Dentist's treatment plan and schedule, and
   c. Radiographs fully depicting existing teeth and associated structures by standard illumination when appropriate.

F. DIALYSIS

AHCCCS covers dialysis and related services furnished to AHCCCS FFS members by qualified providers without PA.

Refer to AMPM Policy 310-E, for covered dialysis services for members not in FES.

Refer to AMPM Policy 1120, for information regarding FES dialysis services.

G. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

EPSDT services provide comprehensive health care, as defined in 9 A.A.C. 22, Article 2, through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health conditions for AHCCCS members who are under 21 years of age. EPSDT also provides for all medically necessary services to treat or ameliorate physical and behavioral health disorders, a defect, or a condition identified in an EPSDT screening. Limitations and exclusions, other than the requirement for medical necessity, do not apply to EPSDT services.

PA for these services is only required as designated in this Policy and in AMPM Policy 430.

Refer to AMPM Policy 430, for complete information regarding EPSDT services (overview, definitions, screening requirements, service standards, provider requirements, and exhibits).

H. EMERGENCY MEDICAL SERVICES

A provider is not required to obtain PA for emergency medical services; however, a provider shall comply with the notification requirements in 9 A.A.C., 22, Article 2, which require that the provider notify the AHCCCS Administration no later than 72 hours after a FFS member's emergent inpatient admission. Notification of emergency admissions may be submitted via AHCCCS online web portal or via fax. DFSM may deny payment for failure to provide timely notice.

Authorization is required when a FFS member remains inpatient 72 hours or more following an emergent admission.

Refer to AMPM Exhibit 310-1, for review of the Rule sections regarding FFS emergency services.

Refer to AMPM Policy 1100 for information regarding the Federal Emergency Services Program.

I. EYE CARE/OPTOMETRY SERVICES

AHCCCS covers eye care/optometric services for members, within limitations. Coverage is provided as described in AMPM Policy 310-G.

Eye examinations and prescriptive lenses are covered for EPSDT and KidsCare members. PA is not required.

Prescriptive lenses for members age 21 and older are only covered when the lenses are the sole visual prosthetic device used by the member after cataract removal surgery.

Cataract removal requires PA. Children needing cataract removal should have a Children's Rehabilitative Services (CRS) application submitted. See the CRS Referrals webpage on the AHCCCS website for application instructions.

For general information on CRS services, please visit the CRS webpage on the AHCCCS website.

J. HOME HEALTH NURSING AND HOME HEALTH AIDE SERVICES

PA is required for all home health nursing and home health aide services, except for the first five home health visits following discharge from an acute facility. PA requests for home health nursing and home health aide services shall be submitted prior to providing services not associated with an acute facility discharge or beyond the first five home health visits following discharge from an acute facility. PA requests shall be accompanied by supporting medical documentation including documentation of the face-to-face encounter requirements outlined in AMPM Policy 310-I.

Refer to AMPM Policy 310-I, for complete information regarding covered home health services.

K. HOSPITAL INPATIENT SERVICE AUTHORIZATION

Hospital inpatient service authorization is a part of the utilization management process that may consist of both PA and continued authorization, contingent upon concurrent review findings. Refer to AMPM Policy 810.

1. Initial Service Authorization:
   a. Under 9 A.A.C. 22, Article 2, the provider shall notify DFSM no later than 72 hours after a FFS member receiving emergency medical services is emergently admitted for inpatient services. DFSM may deny payment for failure to provide timely notice.

2. Providers shall obtain PA for the following inpatient hospital services:
   a. Organ and tissue transplant requests are submitted to the AHCCCS Division of Health Care Management, Medical Management Unit, with the exception of corneal transplants and bone grafts, that are submitted to the DFSM,
   b. Non-emergency admissions, including acute psychiatric hospitalizations, the following applies:
      i. PA requests for FFS members assigned to a Regional Behavioral Health Authority (RBHA) are submitted to the RBHA,
      ii. PA requests for members assigned to a Tribal Regional Behavioral Health Authority (TRBHA) are submitted to DFSM,
      iii. PA requests for FFS members who are not assigned to a RBHA or TRBHA are submitted to the DFSM,
      iv. PA requests for Tribal ALTCS members are submitted to DFSM.
   c. Elective surgery, with the exclusion of any surgeries listed below, and

d. Services or items furnished to cosmetically reconstruct appearance after the onset of trauma or serious injury.

3. The following services do not require PA:
   a. Voluntary sterilization,
   b. Dialysis shunt placement,
   c. Arteriovenous graft placement for dialysis,
   d. Angioplasties or thrombectomies of dialysis shunts,
   e. Angioplasties or thrombectomies of arteriovenous grafts for dialysis, and
   f. Hysteroscopies when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization.

   AHCCCS covers inpatient hospital care after a routine vaginal delivery and inpatient hospital care after a cesarean delivery. PA is not required for hospitalizations that do not exceed 72 hours of inpatient hospital care for a routine vaginal delivery or do not exceed 96 hours of inpatient hospital care for a cesarean delivery.

   The attending health care provider, in consultation with an agreement by the mother, may discharge the mother or newborn prior to the minimum length of stay. A newborn may be granted an extended stay in the hospital of birth when the mother's continued stay in the hospital is medically necessary beyond the minimum 48 or 96 hour stay.

4. For retrospectively eligible members, notification requirements are as follows:
   a. When the member is made eligible while still in the hospital, providers shall notify DFSM no later than 72 hours after the eligibility posting date for emergency hospitalizations, and
   b. When eligibility is posted after the member is discharged from the hospital, the notification requirement in 4(a) will be waived.

5. Payment for services may be denied if the hospital fails to provide timely notification or obtain the required authorization number(s) within the parameters specified in this Policy. However, the issuance of an authorization number does not guarantee payment; documentation provided from the member's medical record shall support the diagnosis for which the authorization was issued, and the claim shall meet clean claims submission requirements.

6. Authorization may be provisional if further review of information or documentation is needed to make a full assessment of the medical necessity for the admission, the service(s), and/or to determine the appropriate length of stay. This information may be obtained through on-site or telephonic concurrent review. Upon approval or denial, the provisional status is removed from the authorization and the provider is notified by letter of the decision.

L. HYSTERECTOMY

1. Hysterectomy services require PA. As specified in 42 CFR 441.255, Hysterectomies are not covered when:
   a. Performed solely for the purpose of rendering an individual permanently incapable of reproducing, or
   b. If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

Refer to AMPM Policy 310-L, for additional information regarding covered hysterectomy services.

2. The PA request shall include:
   a. Medical documentation supporting the medical necessity of the hysterectomy, including prior medical and surgical therapy and results,
   b. Diagnostic test results, and
   c. Copy of the member consent and acknowledgment form, refer to Attachment A of this policy.

The member shall sign consent and acknowledgment of receipt of information that the hysterectomy will render her incapable of reproducing as specified in 42 CFR 441.255.

Pursuant to 42 CFR 441.255(d), the physician performing the hysterectomy must sign a written certification if the individual was already sterile before the hysterectomy or required the hysterectomy due to a life threatening emergency and prior acknowledgement by the individual was not possible.

PA may be granted based on these documents. Providers may use the sample AHCCCS Hysterectomy Consent and Acknowledgement Form (Attachment A), or they may use other formats as long as the forms include the same information and signatures as the AHCCCS hysterectomy acknowledgement form.

Refer to AMPM Policy 310-L for complete information regarding coverage of medically necessary Hysterectomies.

The provider is not required to complete consent to sterilization form prior to performing hysterectomy procedures and the 30-day waiting period required for sterilization does not apply to hysterectomy procedures.

In a life-threatening emergency, authorization is not required, but the physician shall certify in writing that an emergency existed. The physician shall also include a description of the nature of the emergency.

M. MATERNAL AND CHILD HEALTH CARE

AHCCCS covers a comprehensive set of services for pregnant women, newborns, and children, including maternity care, family planning services, EPSDT services, and KidsCare services.

PA is required for medically necessary pregnancy terminations. All authorization requests for medically necessary pregnancy terminations require submission of a completed AHCCCS Certificate of Necessity for Pregnancy Termination (see AMPM Policy 410, Attachment C). Refer to AMPM Policy 410 for complete information regarding coverage of medically necessary Pregnancy Terminations.

Refer to AMPM Chapter 400 for information on maternal and child health care services.

N. MEDICAL EQUIPMENT, MEDICAL APPLIANCES, AND MEDICAL SUPPLIES, AND ORTHOTIC/PROSTHETIC DEVICES

Medical equipment and supplies shall be prescribed by a physician. Refer to AMPM Policy 310-P for complete information regarding coverage of medical equipment and supplies, including face-to-face requirements.

Orthotic and prosthetic devices shall be prescribed by a physician or other appropriate practitioner. PA is required for the purchase of orthotic and prosthetic devices exceeding $300.00. Refer to AMPM Policy 310-JJ for complete information regarding coverage of orthotic and prosthetic devices.

1. The following requirements apply to medical equipment and supplies services:
   a. PA is required for the purchase of medical equipment exceeding $300.00. PA is required for all medical equipment rentals and repairs,
   b. PA is required for consumable medical supplies (as defined in AMPM Policy 310-P) exceeding $100.00 per month,
   c. For members age 21 and over, PA is required for medically necessary incontinence supplies. These incontinence supplies are covered when necessary to treat a condition. In addition, PA requirements for incontinence briefs for ALTCS members age 21 and over are described in AMPM Policy 310-P,
   d. Refer to AMPM Policy 430 for PA requirements and criteria for coverage of incontinence briefs for members under the age of 21, and
   e. All rental equipment requires PA. Medical equipment may be purchased or rented only when there are no reasonable alternative resources from which the medically necessary equipment can be obtained at no cost. The total expense of renting the equipment shall not exceed the purchase price (i.e. if AHCCCS can purchase the equipment for less than the rental fee, AHCCCS will purchase the item).

2. The following items do not require PA:
   a. Oral supplements for ALTCS members, and
   b. Apnea management and training for premature babies up to one year of life.

3. In addition to information required for all PAs specified in AMPM Policy 810, the following information shall be supplied at the time of the PA request:
   a. Prescription or order with ordering provider's name, and dated signature with credentials listed,
   b. Diagnosis indicated by ordering provider,

c. Description of medical condition necessitating the supplies/equipment, and medical justification for supplies/equipment with anticipated outcome (medical/functional),
d. Clinical documentation, including documentation of the face-to face encounter requirements and timeframes (AMPM Policy 310-P),
e. Description of supplies/equipment requested,
f. Duration for use of equipment,
g. Full purchase price plus any additional costs and expected cost if rented,
h. Provider identification number, and
i. Home evaluation, when requested by DFSM.

4. For members age 21 and older, requests for authorization of incontinence supplies shall include the following information:
   a. Diagnosis of a dermatologic condition or other medical/surgical condition requiring medical management by incontinence supplies as dressings,
   b. Defined length of treatment anticipated, and
   c. Prescription for specific incontinence supplies.

5. For ALTCS members age 21 and older, refer to AMPM Policy 310-P for complete information on coverage requirements. Incontinence supplies for Tribal ALTCS members are authorized by the Tribal ALTCS case manager.

O. NURSING FACILITY SERVICES

Nursing Facility (NF) services for FFS acute members are covered by AHCCCS for up to 90 days per benefit year if the member's medical condition would otherwise require hospitalization.

Per 9 A.A.C. 22, Article 2, in lieu of a NF, a Tribal ALTCS member may be placed in an alternative living facility or receive home and community-based services. PA is required for these services prior to admission of the member, except in those cases for which retroactive eligibility precludes the ability to obtain PA. However, the case is subject to medical review.

NF services for Tribal ALTCS members are authorized by the Tribal ALTCS case manager.

Refer to AMPM Policy 310, and AMPM Chapter 1200 for complete information regarding coverage and limitations related to long term care services.

Initial PA will be for a period not to exceed the anticipated enrollment period of the FFS acute eligible member or what is determined as a medically necessary length of stay, whichever is shorter (not to exceed 90 days) and includes any day covered by Medicare.

Reauthorization for continued stay is subject to concurrent utilization review and continued eligibility.

DFSM staff will request hospital personnel and/or NF staff, whichever is appropriate, to initiate an ALTCS application by the 45th day for possible coverage of nursing facility services if it is believed that the member will need a NF stay lasting longer than 90 days.

P. OBSERVATION SERVICES THAT EXCEED 24 HOURS

Observation services are those reasonable and necessary services provided on a hospital's premise for evaluation to determine whether the member should be admitted for inpatient care, discharged, or transferred to another facility.

Observation services include the use of a bed, periodic monitoring by hospital nursing personnel or, if appropriate, other staff necessary to evaluate, stabilize or treat medical conditions of a significant degree of instability and/or disability on an outpatient basis.

It is not Observation when a member with a known diagnosis enters a hospital for a scheduled procedure/treatment that is expected to keep the member in the hospital for less than 24 hours. This is an outpatient procedure, regardless of the hour in which the member presented to the hospital, whether a bed was utilized or whether services were rendered after midnight.

Extended stays after outpatient surgery shall be billed as recovery room extensions.

Refer to AMPM Policy 310-S, for complete information regarding covered outpatient health services.

Observation shall be ordered in writing by a physician, or other individual authorized by hospital staff bylaws, to admit patients to the hospital or to order outpatient diagnostic tests or treatments. There is no maximum time limit for observation services as long as medical necessity exists. The medical record shall document the basis for observation services. Documentation shall minimally include the following:

1. Physician Notes:
   a. Condition necessitating observation,
   b. Justification of need to continue observation, and\or
   c. Discharge plan.

2. Medical Records Documentation:
   a. Orders for observation shall be written as a physician's order, and shall specify "observation,"
   b. Orders for observation shall be signed and dated by a physician within 24 hours of the order,
   c. Follow-up orders shall be written at least every 24 hours,
   d. Changes from "observation to inpatient" or "inpatient to observation" shall be ordered prior to the member's discharge from the facility, and
   e. Physician's daily progress notes shall accompany documentation.

Q. OUTPATIENT SURGERY CENTERS

Ambulatory Surgery Centers (ASC) shall obtain PA from DFSM for all outpatient surgeries performed in this setting. The ASC shall obtain a separate and distinct AHCCCS PA number from that of the surgeon's PA number, prior to providing the elective/non-emergency surgeries.

R. PHYSICIANS AND PRIMARY CARE PROVIDERS

Physicians and other Primary Care Providers (PCPs) shall adhere to the FFS PA requirements.

Refer to AMPM Policy 310 for complete information regarding covered PCP and physician services.

1. Fee-for-service surgeons, or the facility employing the surgeon, shall obtain a separate and distinct AHCCCS PA number from that of the facility PA number prior to providing transplant and elective/non-emergency surgeries (except voluntary sterilization). Refer to Hospital Inpatient Service Authorization. The AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, responds to all transplant requests. Assistant surgeons essential to the service and anesthesiologists do not require a separate PA number.

2. Allergic immunotherapy is not covered for members 21 years of age and over. Allergy testing for members 21 years of age and older is not covered unless the member has sustained an anaphylactic reaction or severe allergic reaction, where further exposure may result in a life-threatening situation. Refer to AMPM Policy 300-T. These services shall be prior authorized by DFSM.

S. FOOT AND ANKLE SERVICES

Medically necessary foot and ankle care is covered for persons age 21 and older. Services provided by a podiatrist or podiatric surgeon, shall be ordered by the primary care provider, attending physician or practitioner. The ordering information shall be documented in the member's medical record. Elective surgical services are subject to PA requirements. Refer to Sections K and Q for PA requirements for elective surgery. PA is not required for evaluation and management services.

Refer to AHCCCS FFS Provider manual for billing requirements.

T. PRESCRIPTION DRUG/PHARMACY SERVICES

All FFS pharmacy PA is conducted through AHCCCS' contracted Pharmacy Benefit Manager (PBM).

All pharmacy claims are subject to post-payment review pursuant to A.R.S §36-2903.01.

Refer to AMPM Policy 310-V, for complete information regarding covered prescription drug/pharmacy services.

Refer to the AHCCCS Website for the AHCCCS AIHP, Acute/Long Term Care, and Behavioral Health Drug Lists, and the Pharmacy/Drug Prior Authorization form.

U. OCCUPATIONAL, PHYSICAL AND SPEECH THERAPIES)

1. Inpatient Services

   For acute FFS members who receive occupational, physical, and speech therapies in an inpatient setting, the PA for the therapies is included in the facility authorization.

   For Tribal ALTCS members who receive therapies in an inpatient setting, contact the Tribal Case Manager for PA requirements. Refer to AMPM Policy 1250-E for further information.

2. Outpatient Services

   No PA is required for covered outpatient occupational and physical therapy services for acute FFS members. Refer to AMPM Policy 310-X for limitations.

   For Tribal ALTCS members who receive therapies in an outpatient setting, contact the Tribal Case Manager for PA requirements. Refer to AMPM Policy 1250-E for further information.

   AHCCCS covers outpatient speech therapy only for members who are under the age of 21 in both the AHCCCS (EPSDT program) and KidsCare programs, and ALTCS-enrolled members of any age. Authorization is not required for therapies for members under 21 years of age.

   Refer to AMPM Policy 310-X for complete information regarding covered services and AMPM Chapter 1200 for complete information regarding rehabilitation services for ALTCS.

V. TOTAL PARENTERAL NUTRITION

AHCCCS covers Total Parenteral Nutrition (TPN) for members 21 years of age and older when it is the only method to maintain adequate weight and strength, and for members who are under the age of 21 in both the Medicaid (EPSDT program) and KidsCare programs when TPN is determined medically necessary. The provision of TPN does not have to meet the criterion of being the sole source of nutrition for EPSDT and KidsCare members. Refer to AMPM Policy 310-AA for complete information regarding covered TPN services.

1. Prior Authorization is required for coverage of TPN. Nursing Facilities and agencies furnishing outpatient TPN services shall obtain PA prior to initiation of service. Telephone requests are given provisional PA.
2. Written medical documentation substantiating compliance with AMPM Policy 310-AA requirements shall be submitted to DFSM to support the authorization request. Medical documentation shall include:
   a. History and physical which describes member's condition and diagnosis,
   b. Physician's orders,
   c. Dietary assessment, including member's weight,
   d. Any pertinent progress notes (nursing/physician), which currently reflect the member's dietary, eating and functional status,
   e. Physician progress notes indicating expected outcome of treatment,
   f. Nursing facility records documenting percentage of each meal's consumption by member, and
   g. Current laboratory data.

W. TRANSPLANTS (ORGAN AND TISSUE)

Providers shall obtain authorization from AHCCCS for all organ and tissue transplant services to be provided to FFS members. Refer to AMPM Policy 310-DD and 310-DD Attachment A for complete information regarding covered transplants, transplant components, related services, and submission requirements.

Pursuant to §1903(v) of the Social Security Act and 9 A.A.C. 22, Article 2, FES members are not eligible for transplantation services.

AHCCCS also requires providers to obtain PA for transplant related services provided to AHCCCS members who have undergone transplants not covered by AHCCCS.

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1. FFS provider responsibilities regarding medically necessary organ and tissue transplant services for eligible members include, but are not limited to:
   a. The submission of prior authorization requests to the AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, for approval of the transplantation and all related transplant components, and
   b. The submission of prior authorization requests to DFSM, for approval of the medically necessary transplant related services that are not included in the transplant components.

Refer to the AHCCCS Reinsurance Policy Manual for additional information. This manual is available on the AHCCCS Website.

2. Per the AHCCCS Transplant Contracts, the transplant facilities are expected to assist the Provider and AHCCCS with:
   a. Transportation, room, and board (lodging) for the transplant candidate and, if needed, the designated caregiver as identified by the transplant facility, to and from medical treatment during the time it is necessary for the member to remain

in close proximity to the transplant center. This includes pre and post-transplant care by the transplant center, and

b. Close proximity for members post allogeneic transplant may be required to be within one hour travel time of the transplant facility if determined to be medically necessary by the transplant specialist.

PA requests for transplant-related services provided to AHCCCS members who have undergone transplants not covered by AHCCCS may be submitted via the AHCCCS online web portal, fax, telephone, or mail.

X. TRANSPORTATION

1. AHCCCS covers the following transportation services:
   a. Emergency transportation,
      i. Emergency transportation does not require PA from DFSM, although such services are only covered to the nearest medical facility, which is medically equipped and staffed to provide appropriate medical or behavioral health care, and
      ii. Emergency transportation to out-of-state facilities is covered only when the out-of-state facility is the nearest appropriate facility,
   b. Medically necessary Non-Emergency Transportation (NEMT) Services are covered as outlined in AMPM Policy 310-BB,
   c. Medically necessary transportation to and from a covered medical or behavioral health service of 100 miles or less, round trip, does not require PA,
   d. PA is always required for medically necessary (non-emergency) air transportation regardless of the number of miles,
   e. Transportation is limited to the cost of transporting the member to the nearest appropriate AHCCCS registered provider capable of meeting the member's medical or behavioral health needs. Transportation shall only be provided to transport the member to and from the required covered medical or behavioral health service, and
   f. Medically necessary maternal and newborn transportation
      i. Medically necessary maternal and newborn transportation, as specified in Chapter 300, does not require PA.

2. For special transportation requests, including but not limited to, specialty transportation needs and travel outside the member's service area/county of residence the following documentation shall accompany the written request as applicable
   a. Physician's order, including medical justification for travel outside the member's service area/county of residence when applicable, case plan notes from an AHCCCS registered behavioral health provider, or other supporting documentation as needed to make a coverage determination,
   b. Descriptions of disability requiring special transport and/or special circumstances,
   c. Type of transportation and need for attendant services, as appropriate,
   d. Estimated cost of transportation, attendant services, meals or lodging, as appropriate, and/or

e. NEMT authorization requests to and from covered behavioral health services for TRBHA members who are enrolled with an MCO for physical health services shall contain a valid behavioral health diagnosis to be authorized by DFSM staff.

PA for transportation will not be issued unless the transportation provider is an AHCCCS registered provider prior to seeking PA.

3. Authorization Requirements to Receive Medically Necessary Non-Emergency Transportation Services to Obtain AHCCCS Covered Physical or Behavioral Health Services.
   a. For AHCCCS American Indian members enrolled with AIHP and /or assigned to a TRBHA, or who receive physical or behavioral health services at an IHS/Tribal 638 facility transportation services are covered on a FFS basis under the following conditions:
      i. The request for transportation services is prior authorized through the DFSM when mileage is greater than 100 miles either one way or round trip. PA is not required for IHS/Tribal 638 transportation providers,
      ii. The member is not able to provide, secure or pay for their own transportation, and free transportation is not available, and
      iii. The transportation is provided to and from either of the following locations:
         1) The nearest appropriate IHS/Tribal 638 physical or behavioral health facility, or the nearest appropriate AHCCCS registered physical or behavioral health provider.
   b. For American Indian members receiving behavioral health services, who are enrolled in either a RBHA or ALTCS MCO, check with the RBHA or MCO for prior authorization requirements.
   c. For MCO enrolled members receiving services with a non-behavioral health (medical) primary diagnosis, contact the MCO for prior authorization requirements.

For Tribal ALTCS members, all medical and behavioral health transportation services are authorized by the Tribal ALTCS case manager.

Refer to AMPM Chapter 800 for complete information regarding prior authorization for Acute FFS members.

Refer to AHCCCS Contractors Operation Manual (ACOM) Policy 205, Ground Ambulance Transportation Reimbursement Guidelines for Non-Contracted Providers, for information regarding reimbursement.
Refer to the AHCCCS FFS Provider Manual or AHCCCS Billing Manual for IHS/Tribal providers for provider registration and billing information. Both of these manuals are available on the AHCCCS Website.

Y. TRIAGE/SCREENING AND EVALUATION OF EMERGENCY MEDICAL CONDITIONS

Triage/emergency medical screening and evaluation services are the medically necessary screening and assessment services provided to FFS members in order to determine

whether or not an emergency medical condition exists, the severity of the condition, and those services necessary to alleviate or stabilize the emergent condition. These services are covered services if they are delivered in an acute care hospital emergency room or Free Standing Emergency Department (FRED).

Medically necessary screening and evaluation services to rule out an emergency condition, or to determine the severity of an emergency medical condition and necessary treatment services required for the emergency medical condition, do not require PA from DFSM.

If the presenting condition assessed during triage/emergency medical screening and evaluation is determined not to be an emergency condition, any further assessment, care and treatment is subject to utilization management requirements.

Providers responsible for triage, screening, and/or evaluation of emergency medical conditions shall submit supporting medical documentation for services rendered. At a minimum, the emergency room record of care and itemized statement shall be submitted when reporting or billing services to DFSM for services provided to FFS members.

Medical review of emergency room records shall consider each case on an individual basis to determine if:

1. The triage/screening services were reasonable, cost-effective and medically necessary to rule out an emergency condition and evaluate the member's medical status, and

2. The evaluation of the member's medical status meets criteria for severity of illness and intensity of service.

   If the provider fails to submit medical records necessary for review, or if the medical records fail to meet the criteria specified in this Policy, the claim is subject to denial.

   Refer to AMPM Policy 810 for a description of notification and PA procedures for inpatient admission or post-assessment therapy.
   Refer to the AHCCCS FFS Provider Manual for information regarding service reporting and billing requirements. This manual is available on the AHCCCS website.

Z. OTHER MEDICAL PROFESSIONAL SERVICES

Under 9 A.A.C. 22, Article 2, the following medical professional services do not require prior authorization if a member receives these services in an inpatient, outpatient or office setting:

1. Voluntary sterilization,
2. Dialysis shunt placement,
3. Arteriovenous graft placement for dialysis,
4. Angioplasties or thrombectomies of dialysis shunts,

5. Angioplasties or thrombectomies of arteriovenous grafts for dialysis,
6. Eye surgery for the treatment of diabetic retinopathy,
7. Eye surgery for the treatment of glaucoma,
8. Eye surgery for the treatment of macular degeneration,
9. Home health visits following an acute hospitalization (limit up to five visits),
10. Hysteroscopies when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization,
11. Outpatient physical and occupational therapy for Acute members age 21 years or older are each limited to:
    a. 15 visits per benefit year to restore a particular skill or function the individual previously had but lost due to injury or disease and maintain that function once restored, and
    b. 15 visits per benefit year to attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired, visits shall not exceed a total of 30 visits for physical therapy per benefit year and 30 visits for occupational therapy per benefit year,
12. Facility services related to wound debridement, or
13. Apnea management and training for premature babies up to one year of life.